Policy context

Oral health impacts on general health and quality of life are more common among people with intellectual and physical disabilities than the general population. This inequality is compounded by their poor access to health care. While public dental care is available to concession card holders for a capped co-payment, resource constraints mean there are significant waiting times for treatment, and less emphasis on preventive care. Consequently, patients with special needs often require emergency treatment for oral disease and this involves hospital admissions and general anaesthesia. Oral health knowledge among this group and their carers, where they require them, is also relatively poor.

Self-care is one capacity that varies widely for these people. Some depend on carers, either family or professionals, for help with everyday activities. Carers are therefore responsible for providing daily personal care, healthy nutrition and regular visits to health services, including oral hygiene care and dental visits. They are often ideally placed to detect problems and facilitate access to services. Training of carers in oral care is strongly recommended in the literature, as studies have identified deficits in knowledge and skill. Among the recommendations are that training in oral care should address the oral care behaviours of carers and psychosocial factors. Examples include carer self-efficacy, and knowledge, confidence and skills in providing oral health care for their care recipients. Although there are few studies evaluating oral care training for carers of people with disabilities, most have demonstrated positive outcomes. In Australia, training in oral care has been limited mostly to aged care settings, with some success.

Other people with special needs who live independently have the capacity to self-care and may work in assisted employment. Nonetheless, the oral health of these people where measured remains relatively poor. Dental treatment and oral health education may offer benefits to this group however, to our knowledge, there remains no published data in Australia on oral health-related interventions for employees with disabilities.

This study aimed to benefit the oral health and quality of life of two groups of people with special needs: ‘care recipients’ (directly and via their carers) and ‘employees’. The study aims reflect the different approaches used.

For carers and care recipients:

> To conduct and evaluate a home-based intervention, training carers in providing improved oral care for adults with disabilities.

For employees:

> To conduct and evaluate a workplace intervention combining oral health education and timely referral for dental treatment.
Policy options

The first intervention showed preliminary evidence that carers can be trained to improve their knowledge and confidence in oral care, and they are capable of assessing their care recipients’ oral health and the need for referral. The second intervention suggested that providing regular oral health education and enabling referral to treatment improves self-rated oral health and quality of life among employees with disabilities.

We recommend:

> Implementation of regular training in oral care and assessment for carers of people with disabilities. Encouragement and incentive should be provided to their employers to undertake training.

> Training in oral care for carers should be integrated with evaluation and coordinated with public dental services and dental professionals specialised in care for people with disabilities.

> Encouragement and incentives for employers of people with disabilities to implement workplace programs for oral health education and referral for treatment.

> Expansion of opportunities within public dental care for people with disabilities to gain treatment. These patients need to be actively followed up to ensure that they attend appointments.

> Further research to identify barriers and enablers that facilitate the training of carers of people with disabilities. These findings could then inform the development of a coordinated approach to training that would benefit carers and their care recipients.
Key findings

INTERVENTION FOR CARERS AND CARE RECIPIENTS

> Findings from this intervention suggested that the training improved knowledge and confidence in oral care among the carers.

> Oral health assessments showed high carer-dentist agreement in most categories, reflecting carers’ capacity to assess oral health to the extent needed for referral to dental professionals.

> Poor carer efficacy in controlling snacking between meals was not improved by the intervention. Discussion among carers, managers and care recipients’ parent/guardians is recommended on this lack of efficacy.

> The integrated training and evaluation approach appeared to be effective.

INTERVENTION FOR EMPLOYEES

> Findings suggested that providing regular oral health education combined with enabling referral to treatment improved self-rated oral health and oral health-related quality of life. However, the effects of education and treatment were not able to be separated.

> The prevalence of impacts on oral health-related quality of life was low and may reflect the higher pain threshold of people with disabilities.

> Dental fear and cost were identified as barriers to care.

> No significant change was observed in measured oral health behaviours, i.e. tooth brushing frequency and consumption of sweet food and drink. However, there was anecdotal evidence of improvement in unmeasured behaviours.

The absence of control groups limited the capacity of either intervention to discern a causal effect. It is evident that a larger, broader sample in controlled interventions would address these issues and advance our understanding in this area.

Challenges to data collection are often encountered when working with people with disabilities. To overcome these, workshops were conducted which involved managers and carers of disability organisations and dental professionals involved in care for adults with disabilities. Organisations which provided care and employment volunteered their involvement in the study, and approached carers and employees respectively for their participation. The intervention for carers comprised theory and practical training sessions and was evaluated by (1) assessing change in carer psychosocial factors pre- to post-training, and (2) benchmarking to a dentist the oral health assessment of carers post-training. For employees, the intervention combined oral health education sessions and timely referral for dental treatment where needed. This was evaluated by assessing change in self-rated oral health, quality of life and oral health behaviours pre- and post-intervention.

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